ship depends on the actual behaviors, attitudes and interactions as they are perceived through the expectations that one brings from past experiences with similar people or similar situations. In this concept, both parties try to make plausible sense of their relationship, both influence the way the other perceives them and both are influenced by the other's actual behaviors and by expectations that derive from their own personal pasts. In this conception it is not immediately clear what is realistic and what is distorted and how much a patient's way of construing the relationship makes sense in terms of how the therapist's actual attitudes and behavior are remindful of or confirm perceptions and expectations that were originally grounded in the patient's earlier life experiences.

This newer conception of the transference entails in turn an altered handling of it. Rather than seeing transference manifestations, with their roots in past experiences, only in terms of their inappropriateness to the present relationship and therefore as unrealistic, a physician might now look first to the current interaction with a patient to see what in it might be plausibly construed by the patient as if it were the same as, or a repetition of, an earlier relationship pattern. This becomes then an additional avenue to understanding and to tactful handling and tactful behavioral alteration by a physician in interacting with patients.

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Indications for Monitoring Psychotherapeutic Drug Concentrations

THE MEASUREMENT of concentrations of psychotherapeutic drugs in serum has recently been introduced into the field of psychiatry. The clinical indications for these drug level measurements are still being developed but the following generalizations can be sifted out of the literature.

Lithium Ion

Lithium ion is readily determined in serum. The recommended therapeutic range of 0.8 to 1.4 mmol per liter may be valid only for cases of acute mania; maintenance levels of 0.4 mmol per liter may be sufficient. Optimal maintenance levels and schedules are subjects of much current investigation.

Tricyclic Antidepressants

Suggested optimal tricyclic antidepressant concentrations are 100 to 300 ng per ml (400 to 1,100 nmol per liter) for desipramine hydrochloride, 50 to 150 ng per ml (200 to 550 nmol per liter) for nortriptyline hydrochloride and 100 to 200 ng per ml (400 to 750 nmol per liter) for protriptyline hydrochloride. Some investigators have noted deterioration at concentrations greater than 150 ng per ml of nortriptyline. For the tertiary amines, the following tentative ranges have been proposed: imipramine hydrochloride plus desipramine, 150 to 300 ng per ml; amitriptyline hydrochloride plus nortriptyline, 150 to 300 ng per ml (nortriptyline and desipramine are formed metabolically from amitriptyline and imipramine, respectively).

The utility of measuring such concentrations is controversial but appears to be most useful in cases of poor treatment response. The drug concentrations can then be used to assess whether poor compliance (which may exceed 50%) or aberrant metabolism is present. The use of drug concentrations is advocated to avoid toxic effects in high-risk populations, such as cardiac patients or elderly persons. Beyond these indications, the use of blood concentrations of tricyclic antidepressants is not considered cost effective by most authors.

Neuroleptics

Neuroleptic drug monitoring is in its infancy. Haloperidol is the best studied drug. Available studies suggest that both excessively high or low levels of haloperidol are associated with a poor clinical outcome. Studies are in progress with thiothixene and fluphenazine hydrochloride. At present no indications for measuring antipsychotic drug activity have been developed.

Benzodiazepines

Although benzodiazepines can be readily assayed, there is little agreement on the interpretation of serum concentrations. A major problem is the heterogeneity of conditions treatable with these agents.

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Mass Hysteria

RECORDED IN THE medical literature for centuries, mass hysteria continues to perplex both clinician and researcher. Although recent studies have clarified the characteristic patterns of such epidemics, sudden outbreaks of illness routinely stir up controversy about whether they are physical or psychological in origin. With public alarm about environmental pollution increasing during the past decade, attempts to find toxic causes for these epidemics have intensified.

An estimated four to six separate outbreaks of hysteria reach public attention each year, but the actual incidence is unknown. Mass hysteria is defined as the occurrence in a group of people of a constellation of physical symptoms suggesting an organic illness but resulting from a psychological cause, with the typical epidemic affecting from 30 to several hundred people. The characteristic features of mass hysteria that help differentiate such epidemics from those due to physical causes include the absence of laboratory results and physical findings confirming a specific organic cause; a